MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

06371

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

136 John Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 136 John Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ada Lillian Albert

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William Albert

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feby. 10, 1870

8. AGE: Years: 75 | Months: 3 | Days: 27 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia

(Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER — 12. Name: James Elbon

13. Birthplace: Va.

MOTHER — 14. Maiden name: Eliza Hensell

15. Birthplace: Va.

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 9, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. June 9 1945 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6, 1945 7:50 P. M. (M)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 - 1945, to June 6 1945

and that I last saw alive on June 6 - 45 1945

Immediate cause of death	DURATION
Acute Pneumonia	4 days
Due to Grippe	
Due to General Arteriosclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address Hagerstown Md. Date signed 6/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 12 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06372

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred:
51 Madison Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 51 Madison Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Andrew E. Armstrong

3.(b) Social Security Number: 705-10-6240

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Helen Armstrong

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): May 6, 1880

8. AGE: Years	Months	Days	If less than one day
65	1	1	hrs. min.

9. Birthplace: Middleburg, Franklin Co. Pa.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: W.M.R.R. Co.

FATHER
12. Name: Jacob Armstrong
13. Birthplace: Mercersburg, Pa.

MOTHER
14. Maiden name: Margaret E. Coral
15. Birthplace: Cavetown, Maryland

16. Informant: Mrs. Andrew E. Armstrong

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-10-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. June 10 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7th 1945, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5th 1945, to June 7th 1945, and that I last saw h alive on June 7th 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	2 days
Due to Arteria-sclerosis	5 yrs
Due to Chronic nephritis	3 yrs.
Other conditions	

(Includa pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. P. Bender M.D.
M. D. or other

Address Hagerstown Md. Date signed June 9 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 12 1945
BUREAU V.S.

Dr. Poole

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

06373

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4½ Yrs.
Hospital, Institution, or street address where death occurred:
Wash. Co. Home
How long in hospital or institution? 4½ Yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Washington County Home
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Benjiman F Baker

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife: Anne
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 8 1852

8. AGE: Years	Months	Days	If less than one day
92	8	15	____ hrs. ____ min.

9. Birthplace: Greencastle Franklin. Co. Pa.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired

FATHER
12. Name: Fredrick Baker
13. Birthplace: Greencastle Pa.

MOTHER
14. Maiden name: Mary Zentmyer
15. Birthplace: Waynesboro Pa.

18. Informant: Walter Grove
Address: Waynesboro Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/26/45 (month) (day) (year)
Cemetery or crematory: Green Hill Cemetery
Location: Waynesboro, Pa.
18. Funeral director: Walter Y. Grove
Address: Waynesboro, Pa.

19. June 25 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23 1945 at 11:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to June 23 1945 and that I last saw h[illegible] alive on June 19 1945

Immediate cause of death	DURATION
Due to: Chronic Interstitial Nephritis	1 yr.
Due to: Uremia	1 wk.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Ernest H Poole M.D. M. D. or other
Address: Hagerstown Md Date signed: 6/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 28 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

06374

Reg. Dist. No. 301

1. PLACE OF DEATH:

County: Washington

City or town: Rural Downsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Potomac River- at Dellingers

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 127 N. Mulberry Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: June Ella Barnes

3.(b) Social Security Number: 214-09-3405

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B.(b) Name of husband or wife: John Barnes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 8, 1915

8. AGE: Years	Months	Days	If less than one day
30	0	9	..... hrs. ..... min.

9. Birthplace: Funkstown, Wash. Md.
(Town, county, and state)

10. Usual occupation: Flat Stitcher - Goodlum shoe

11. Industry or business: mfg. Hagerstown - Md.

FATHER
12. Name: Charles A. Fahrney

13. Birthplace: Leitersburg, Md.

MOTHER
14. Maiden name: Nettie Itnyre

15. Birthplace: Benevola, Md.

16. Informant: Mrs. Nettie Fahrney

Address: 127 N. Mulberry St. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21, 1945 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown, Md.

16. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. June 21 1945 (Date rec'd by registrar) Mrs. E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17, 1945 19 6:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suffocation by drowning	
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/17/45

Where did injury occur? Near Downsville (City or town) Wash. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Potomac River

Means of injury Drowned Injured at work? No

DEPUTY MEDICAL EXAM.
WASH. CO., MD.

23. SIGNATURE: Dr. Robert Wells
M. D. or other

Address: Hagerstown, Md. Date signed 6/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 23 1945
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

CERTIFICATE OF DEATH

06375 Reg. Dist. No. 307

1. PLACE OF DEATH:
County Washington
City or town Hagerstown Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Frederick
City or town Thurmont Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war WW

3.(a) FULL NAME Martha Agnes Bartgis

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife George Bartgis
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 22 - 1868

8. AGE: Years 75 | Months 5 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Littlestown Pa
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Schildt
13. Birthplace Thurmont

MOTHER
14. Maiden name Catherine Eichman
15. Birthplace Unknown

16. Informant Mrs Preston Carl
Address Marburn Rd Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10-45 (month) (day) (year)
Cemetery or crematory Mt Lord Cem
Location Woodsboro Md

18. Funeral director D. L. Creager & Son
Address Thurmont Md

19. June 7 1945 Clark Roward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1944 to June 6 1945 and that I last saw h alive on about June 5 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension Renal	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Milton Seymour M.D.
M. D. or other
Address Hagerstown Md Date signed 6-7-45

VS A15 (T) (1) (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Mr. Layman.

RECEIVED
JUN 9 1945
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20)

CERTIFICATE OF DEATH

06376

Reg. Dist. No. 306

1. PLACE OF DEATH:
County: Washington
City or town: Near Smithsburg - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, Institution, or street address where death occurred:
Smithsburg R. 2
How long in hospital or Institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: near Smithsburg Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Smithsburg Md. R. 2
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Ida Frey Beard

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Frank C. Beard
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August - 23 . 1884

8. AGE: Years	Months	Days	If less than one day
60	10	2	..... hrs. ..... min.

9. Birthplace: Near Wolfsville Fred. Co. Md.
(Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: Own Home
FATHER 12. Name: James Frey
13. Birthplace: Wolfsville Frd. Co. Md.
MOTHER 14. Maiden name: Malinda Hayes
15. Birthplace: Wolfsville Fred. Co. Md.
16. Informant: Mrs. J. C. Gardiner
Address: Smithsburg Md. R. 2
17. Burial. (Burial, cremation, or removal. Which?) Date thereof June 30. 1945 (month) (day) (year)
Cemetery or crematory: Smithsburg Cemetery
Location: Smithsburg Md.
18. Funeral director: Chas. T. Bast & Sons
Address: Boonsboro Md.
19. June 28 1945 (Date rec'd by registrar) Geo. W. Ferguson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 1945 at 6 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1945 to June 25 1945
and that I last saw h[illegible] alive on June 25 1945
Immediate cause of death: Carcinoma of Breast — DURATION: 3 mo
Due to: Carcinoma of Left Breast — 3 yrs
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. C. Hoffler M. D. Mother
Address: Smithsburg Md. Date signed 6/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 13 1965
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

06377

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County: Washington

City or town: Rural Hagerstown R D 3
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, institution, or street address where death occurred: Hagerstown, Md. R D 3 Sharpsburg Pike

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Sharpsburg Pike
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American War

3.(a) FULL NAME: William S. Bender

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B.(b) Name of husband or wife: Mary Bender B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 22nd 1874

8. AGE:	Years	Months	Days	If less than one day
	70	11	17	hrs. min.

9. Birthplace: Sharpsburg, Wash. Co., Md. (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER
12. Name: Jacob Bender
13. Birthplace: Wash. Co., Md.

MOTHER
14. Maiden name: Barbara Johnson
15. Birthplace: Wash. Co., Md.

16. Informant: Mrs. Walter Weaver
Address: Hagerstown, Md. R D 3

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 11 45 (month) (day) (year)

Cemetery or crematory: National Cemetery

Location: Sharpsburg, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. June 11, 1945 (Date rec'd by registrar) John W. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8, 1945 12:15 A. M. P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 38 to June 7'45 19

and that I last saw him alive on June 7'45 19

Immediate cause of death	DURATION
Diabetes mellitus	7 yrs
Due to: cerebral thrombosis	14 d.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L. Robert Wells, M.D. M. D. or coroner

Address: Hagerstown, Md. Date signed: 6/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 16 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (127-E)

06378

2

CERTIFICATE OF DEATH

Reg. Dist. No. 302

File No. G 96 JUL 10 1945

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Rural Williamsport R D 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME David High Bohrer

3. (b) Social Security Number 212-24-5904

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ida Bohrer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 30, ~~1887~~ 1892

8. AGE: Years 53 | Months 1 | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace Washington County, Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name George W. Bohrer

13. Birthplace Wash. Co., Md.

MOTHER 14. Maiden name Mary Hinkle

15. Birthplace Wash. Co., Md.

16. Informant Mrs. Ida Bohrer

Address Williamsport, Md. R D 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3, 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Clear Spring, Md.

18. Funeral director Snyder-Rowland Funeral Home

Address Clear Spring, Md.

19. July 2, 1945 (Date rec'd by registrar) Chas. H. Byers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1945 19..... at A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1945 to June 30 1945

and that I last saw h~~im~~ alive on June 29 1945

Immediate cause of death	DURATION
General peritonitis	3 days
Due to Perforation of gall bladder	7
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations General peritonitis

Date of op.

Autopsy results Perforation of gall bladder

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Peregrine Wroth, Jr. M. D. or other

Address Hagerstown, Md. Date signed 7/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 1

RECEIVED
JUL 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06379

(183)

Reg. Diat. No. 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Rural-Downsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Potomac River- at Dellingers

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. 127 N. Mulberry St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Constance Lou Brashears

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 8, 1935

8. AGE: Years: 9 | Months: 9 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Hagerstown, Wash. Co., Md. (Town, county, and state)

10. Usual occupation: School Student

11. Industry or business

FATHER — 12. Name: Marlin Brashears

FATHER — 13. Birthplace: Wash. Co., Md.

MOTHER — 14. Maiden name: Genevieve Fahrney

MOTHER — 15. Birthplace: Funkstown, Md.

16. Informant: Mrs. Nettie Fahrney

Address: 127 N. Mulberry St. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21 1945 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown, Md.

16. Funeral director: Fred W. Kreiss

Address: Hagerstown, Md.

19 June 21 19 45 Mrs E Lee McElroy Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17, 1945 - 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suffocation by	
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 6/17/45

Where did injury occur? Near Downsville (City or town) Wash. Co. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Potomac River

Means of injury: Drowned Injured at work? No

23. SIGNATURE: H. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D. or other

Address: Hagerstown, Md. Date signed 6/20/45

RECEIVED
JUN 23 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-7)

CERTIFICATE OF DEATH

06380

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Rural Williamsport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
near Williamsport
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. R. #2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Clyde Lester Bragunier

3.(b) Social Security Number: 705-10-6583

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith A. Bragunier
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 10, 1885

8. AGE: Years	Months	Days	If less than one day
60	1	7	..... hrs. ..... min.

9. Birthplace: Hagerstown, Washington Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business: Western Maryland R. R.

FATHER
12. Name: James Daniel Bragunier
13. Birthplace: Hagerstown

MOTHER
14. Maiden name: Elizabeth Hose
15. Birthplace: Hagerstown, Md.

16. Informant: Mrs. Edith A. Bragunier
Address: R. R. 2, Williamsport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20, 1945 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown, Md.

18. Funeral director: L. F. Reecher
Address: Rest Haven Chapel

19. June 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1945 at 9 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to June 17 1945, and that I last saw h... alive on June 17 1945.

Immediate cause of death	DURATION
(a) Malignant growth in left lung	
Metastasis to small bowel	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: Carcinoma, Pathological report submitted later
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Williamsport Md. Date signed: June 19, 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 22 1945
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

06381

Reg. Dist. No. 30 2

1. PLACE OF DEATH:
County Washington
City or town Hagerstown MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 Days
Hospital, institution, or street address where death occurred: Washington County Hagerstown MD
How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Rural Williamsport MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. R F D Williamsport MD
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles I Brill

3. (b) Social Security Number None

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced ~~Married~~ Widowed
6.(b) Name of husband or wife Susanne Brill
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) 1870 Feb. 28

8. AGE: Years 75 Months 3 Days 8 If less than one day ... hrs. ... min.

9. Birthplace Boonsboro MD Washington (city, county, and state)
10. Usual occupation Farmer
11. Industry or business Farmer

FATHER
12. Name Josepth Brill
13. Birthplace Boonsboro Maryland

MOTHER
14. Maiden name Jennet Harper
15. Birthplace Boonsboro MD

16. Informant Mrs Oscar Harbaugh
Address R. F.D 2 Williamsport MD

17. Burial Date thereof 6 12 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Bakersville
Location Bakersville Maryland

18. Funeral director Mrs Albert Leaf
Address Williamsport MD

19. June 11 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10/45 19... at 1:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/28/45 19..., to 6/10/45 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Coronary Occlusion	1 Day
Due to Arteriosclerotic Cardio-Vascular Renal Disease	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE C F Young M. D. or other
Address Williamsport, MD Date signed 6/11/45

RECEIVED
JUN 13 1945
BUREAU V.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

063882

Reg. Dist. No. 582

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: Washington County Hospital

How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 116 W. Magnolia Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Carrie Schock Burger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Harry D. Burger

8.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) September 13, 1882

8. AGE: Years	Months	Days	If less than one day
62	8	25	....hrs. ....min.

9. Birthplace Hagerstown, Wash.Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George P. Lambert

13. Birthplace Leitersburg, Maryland

MOTHER 14. Maiden name Mary Schock

15. Birthplace Hagerstown, Maryland

16. Informant Harry Burger

Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-5-45 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. June 4 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1945 at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9, 1945 to June 3, 1945 and that I last saw her alive on June 2, 1945

Immediate cause of death	DURATION
Hypostatic Pneumonia	1 day
Due to	
Due to	
Other conditions Chronic pyonephritis	6 yrs
Fracture of right femur	7 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4/17/45

Where did injury occur? Hagerstown, Wash. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fell out 2nd Story Window Injured at work? no

23. SIGNATURE B. D. Burger M. D.
M. D. or other

Address 148 W. Washington St. Date signed 6/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 6 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

CERTIFICATE OF DEATH

06383

Reg. Dist. No. 301

1. PLACE OF DEATH:
County Washington
City or town Near Downsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Penna County Franklin
City or town Waynesboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 East N St
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Wilbur D Byers

3. (b) Social Security Number 173-03-3395

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Clara E Shupp
6.(c) If alive, give age 46 years
7. Birth date of deceased (mo., day, yr.) March 5 1896

8. AGE: Years	Months	Days	If less than one day
49	3	12	hrs. min.

9. Birthplace Boonsboro Md (Town, county, and state)
10. Usual occupation Truck Driver
11. Industry or business Grover Brothers
FATHER 12. Name Henry Byers
13. Birthplace Mercersburg Pa
MOTHER 14. Maiden name Effie Anthony
15. Birthplace Leitersburg Md
16. Informant Mrs Clara Byers
Address Waynesboro Penna
17. Removal (Burial, cremation, or removal. Which?) Date thereof 6 22 1945 (month) (day) (year)
Cemetery or crematory Price Cemetery
Location Near Waynesboro Pa
18. Funeral director Walter G Grove
Address Waynesboro Penna
June 25 1945 Mrs E Lee McElroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about P

20. DATE OF DEATH June 17 1945, at 6:15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suffocation	
Due to Leg drawing	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations no
Date of op.
Autopsy results no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of June 17-45
Where did injury occur? Williamsport R#0 Washington Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Potomac River
Means of injury Boat-turned over Injured at work? no

23. SIGNATURE Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.
M. D. or other
Address Hagerstown Md Date signed June 19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 27 1945
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

CERTIFICATE OF DEATH

06384 302

Reg. Dist. No.

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 931 Hamilton Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Harry A. Clevidence

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Mary E. Clevidence

8.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): September 7, 1866

8. AGE:

Years	Months	Days	If less than one day
78	9	2	...hrs. ...min.

9. Birthplace: Hagerstown, Wash.Co.Md.
(Town, county, and state)

10. Usual occupation: Retired Tailor

11. Industry or business:

FATHER
12. Name: George Clevidence
13. Birthplace: Hagerstown, Maryland

MOTHER
14. Maiden name: Ellen Chrissinger
15. Birthplace: Hagerstown, Maryland

16. Informant: Mrs. Harry A. Clevidence
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-12-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. June 10 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/9 1945 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to June 9 1945 and that I last saw h... alive on June 9 1945

Immediate cause of death	DURATION
Chronic Endocarditis	?
" Nephritis.	?
Due to Hypertrophy Prostate.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: V. Van Stuellen M. D. or other

DR. VICTOR D. MILLER 131 W. WASHINGTON, ST. HAGERSTOWN, MD.

Address: Date signed 6/9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 12 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

06385

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County: Washington

City or town: Breathedsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4/20/45

Hospital, institution, or street address where death occurred:
MD. STATE REF. FOR MALES,

How long in hospital or institution? 4/20/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: [redacted]

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 714 N. Carey St.
(If rural, give LOCATION)

2.(a) If veteran, name war: no ✓

3.(a) FULL NAME: DIX, John Daniel

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Elizabeth Dix

6.(c) If alive, give age: 2I years

7. Birth date of deceased (mo., day, yr.): 7/29/22

8. AGE: Years	Months	Days	If less than one day
22	10	22	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business:

FATHER
12. Name: Jerome Dix
13. Birthplace: Balto. Md.

MOTHER
14. Maiden name: Elizabeth Dickson
15. Birthplace: Balto. Md.

18. Informant: MD. STATE REF. FOR MALES
Address: Breathedsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 22 45 (month) (day) (year)
Cemetery or crematory: MD. State Ref. For Males
Location: Breathedsville, Md.

18. Funeral director: Andrew K Coffman
Address: Hagerstown Md.

19. June 22, 1945 (Date rec'd by registrar) John H. Bart Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1945, at 2:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
and that I last saw him alive on 6-21-45 19....

Immediate cause of death	DURATION
Pulmonary T.B.	5 Yrs
Due to	
Due to	
Other conditions Congestive Heart Failure	Coma

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. Earl Young M.D.
M. D. or other

Address: Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 26 1945
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★ 16386

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Maugansville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, institution, or street address where death occurred:
Mennonnite Home, Maugansville

How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Maugansville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Maugansville, Route #4
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Catherine Eshelman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 17, 1872

8. AGE: Years	Months	Days	If less than one day
73	0	4	hrs. min.

9. Birthplace: Franklin County, Pa.
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business:

FATHER — 12. Name: Christ Eshelman

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mattie Weaver

15. Birthplace: Franklin County, Pa.

16. Informant: Harry Eshelman

Address: Shippensburg, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-23-45 (month) (day) (year)

Cemetery or crematory: Menn. Church Cem.

Location: Franklin County, Pa.

18. Funeral director: Robert A. Sellers

Address: Chambersburg, Pa.

19. June 21 19 45 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 - 45 19 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-40 19 to 6-21-45 19

and that I last saw alive on 6-12-45 19

Immediate cause of death	DURATION
Chr. Myocarditis	
Due to Arteriosclerosis	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: F. W. Oellig M. D. or other

Address: Hagerstown Date signed 6/24/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 23 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

06387

Reg. Dist. No. 301

1. PLACE OF DEATH:

County: Washington

City or town: Rural Downsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Potomac River at Dellingers

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 213 Jefferson Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Paul Richard Ernde

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 28, 1910

8. AGE: Years	Months	Days	If less than one day
35	0	21	..... hrs. ..... min.

9. Birthplace: Hagerstown - Wash. - Md.
(Town, county, and state)

10. Usual occupation: Machine Repairman

11. Industry or business

FATHER
12. Name: Trebe C. Ernde
13. Birthplace: Hagerstown, Md.

MOTHER
14. Maiden name: Eliza J. Osborne
15. Birthplace: Hagerstown, Md.

16. Informant: Trebe C. Ernde
Address: 213 Jefferson St. - Hagerstown,

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kreiss

Address: Hagerstown, Md.

19. June 21 1945 (Date rec'd by registrar) Mrs E Lu McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17, 1945 6:00 at P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suffocation by	
Due to Drowning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/17/45

Where did injury occur? Near Downsville (City or town) Washington (County) Md. (State)

Injured at home, farm, industry, public place (where?) Potomac River

Means of injury Drowning Injured at work? No.

DEPUTY MEDICAL EXAM.
WASH. CO., MD.

23. SIGNATURE: J. Robin Howell M. D. or other

Address: Hagerstown, Md. Date signed 6/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 23 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

06388

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington (WITHIN CORPORATE LIMITS)

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington (WITHIN CORPORATE LIMITS)

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 26 S. Mulberry Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Fleisher

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Hannah Fleisher

8.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): -------- 1861

8. AGE: Years	Months	Days	If less than one day
83	--	--	..... hrs. ..... min.

9. Birthplace: -------- Latvia (Town, county, and state)

10. Usual occupation: Retired Merchant

11. Industry or business:

FATHER 12. Name: John Fleisher

FATHER 13. Birthplace: Latvia

MOTHER 14. Maiden name: Sarah --------

MOTHER 15. Birthplace: Latvia

18. Informant: Mrs. Hannah Fleisher

Address: 26 S. Mulberry St- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5, 1945 (month) (day) (year)

Cemetery or crematory: Hebrew Cemetery

Location: Half Way Dist. Hagerstown, R D

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. June 4 1945 (Date rec'd by registrar) Chas. H. Brewer, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4, 1945 9:00 A.M., at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1945 to June 4 1945

and that I last saw h. alive on June 4 1945

Immediate cause of death: Uremia Myocarditis

DURATION: 1 day

Due to:

Due to:

Other conditions: Chronic Bronchitis, Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. N. Bradley M. D. or other

Address: Hagerstown, Md. Date signed

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 6 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34a)

CERTIFICATE OF DEATH

16389

Reg. Dist. No. 30d

1. PLACE OF DEATH:

County: Washington

City or town: Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wash.

City or town: Sharpsburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ella May Funkhouser

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: J. W. Funkhouser

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 8, 1873

8. AGE: Years: 72 | Months: 1 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Antietam-Wash. Co. Maryland
(Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

MOTHER / FATHER

12. Name: Joseph Cox

13. Birthplace: Martisburg, W. Va.

14. Maiden name: Clara Hebb

15. Birthplace: Sharpsburg, Md.

16. Informant: Mrs. Emma Himes

Address: Sharpsburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27 1945 (month) (day) (year)

Cemetery or crematory: Mt. View

Location: Sharpsburg, Md.

18. Funeral director: R. I. Earnshaw

Address: Keedysville, Md.

19 6-26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1945, at 1 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 19 44 to June 24 1945, and that I last saw h[illegible] alive on June 24 1945

Immediate cause of death	DURATION
Coronary Thrombosis	4 hours.
Due to, Terminal Arteriosclerosis	9 "
Due to, Hypertension	1 "
Other conditions, Gastro-Enteritis (Non Surgical)	24 hours.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Walter H. Shively M.D. M. D. or other

Address: Sharpsburg, Md. Date signed 6-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 6 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7)

CERTIFICATE OF DEATH

06390

Reg. Dist. No. 307

1. PLACE OF DEATH:

County Washington

City or town Dargan, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No. Dargan, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Washington Gay

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Mary E. Gay

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 7 1878

8. AGE: Years	Months	Days	If less than one day
67 66	9	16	..... hrs. ..... min.

9. Birthplace Shepherdstown, W.Va.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Stone Quarry

FATHER 12. Name James Gay

FATHER 13. Birthplace Shepherdstown, W.Va.

MOTHER 14. Maiden name Not Known

MOTHER 15. Birthplace Not Known

16. Informant Raymond L. Gay

Address Harpers Ferry, W.Va. R.R.# 1

17. Burial Date thereof June 25 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Samples Manor, Md.

18. Funeral director J. H. Castles,

Address Bolivar, W.Va.

19. June 24 1945 Cornelius W. Castle Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1945 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to 6/23 19.. and that I last saw him alive on June 20 19..

Immediate cause of death	DURATION
Due to (a) Arteriosclerosis	
Due to (b) Senility	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Shewey M.D.
M. D. or other

Address Shepherdstown, Md. Date signed 6/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 29 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

CERTIFICATE OF DEATH

Reg. Dist. No. 0639 203

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Washington
City or town Clear Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Clear Spring Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sharon E. Gordon

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28 1944

8. AGE: Years	Months	Days	If less than one day
0	5	23	hrs. min.

9. Birthplace Washington Co. (Town, county, and state)
10. Usual occupation Infant.
11. Industry or business

FATHER
12. Name Martin R. Gordon
13. Birthplace Washington Co.

MOTHER
14. Maiden name Kathrin Lisle
15. Birthplace New Jersey

16. Informant Kathrin Gordon
Address Clear Spring R.F.D. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 24 1945 (month) (day) (year)
Cemetery or crematory Pleasant Hill
Location Pleasant Hill Near Greencastle
18. Funeral director Snyder-Rowland
Address Clear Spring Md

19. June 24 19 45 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 '45 19 about 10:45 at A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Due to Suffocation by strangulation	
Due to between bed and crib	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations no
Date of op.
Autopsy results no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of June 21'45
Where did injury occur? Clear Spring (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?) home
Means of injury caught between bed & crib Injured at work?

DEPUTY MEDICAL EXAM.
23. SIGNATURE J. Robert Weels WASH. CO., MD.
M. D. or other
Address Hagerstown, Md. Date signed 6/21/45

RECEIVED
JUL 7 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16)

CERTIFICATE OF DEATH

06392

Reg. Dist. No. 3W

1. PLACE OF DEATH:

County: Washington County

City or town: Sharpsburg Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Sharpsburg Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Sharpsburg Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Max Leonard Grey

3. (b) Social Security Number: 705-10-6805

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Divorced

6.(b) Name of husband or wife: Clarisa Cook Grey

Divorced 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): March 27 1891

8. AGE: Years	Months	Days	If less than one day
54	3	2	...hrs. ...min.

9. Birthplace: Sharpsburg Maryland (Town, county, and state)

10. Usual occupation: Arch Brickman WMRR

11. Industry or business: Rail Raad Western Md.

FATHER
12. Name: Alexander Grey
13. Birthplace: Sharpsburg Md.

MOTHER
14. Maiden name: Ida Grey
15. Birthplace: Sharpsburg Md.

16. Informant: Mrs. Harry Callaman (sister
Address: Sharpsburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16 1945 (month) (day) (year)

Cemetery or crematory: Tolson Chapel Cemetery

Location: Sharpsburg Maryland

18. Funeral director: Edith V Leaf

Address

19. 6-16 45 (Date rec'd by registrar) Ed V Beeson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13th 1945 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Gun shot wound	
Due to: Thru chest	
Due to: Hemorrhage & Shock	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No

...Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of 6/13th/45

Where did injury occur? Sharpsburg Wash Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Gun shot wound Injured at work? no

23. SIGNATURE: E. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.

Address: Hagerstown, Md. Date signed: 6/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUL 6 1965
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

06393 Reg. Diat. No. 3.01

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7West Potomac
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles Edgar Grimes

3.(b) Social Security Number

4. Sex	5. Color or race	6. If single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Grace Rhodes

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) May 26 1866

8. AGE: Years	Months	Days	If less than one day
79		6	....hrs. ....min.

9. Birthplace Williamsport Md (Town, county, and state)

10. Usual occupation retired Forman Tannery

11. Industry or business Leather

FATHER
12. Name William E. Grimes
13. Birthplace Williamsport R.F.D. Md

MOTHER
14. Maiden name Susan McElroy
15. Birthplace Williamsport R.F.D Md

16. Informant Frances Grimes
Address 7Potomac St Williamsport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 3 1945 (month) (day) (year)

Cemetery or crematory Riverview Cem
Location Williamsport Md

18. Funeral director Edith V. Leaf
Address 7 Church Williamsport Md

19. June 3 1945 (Date rec'd by registrar) Mrs E Lu McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1945 at 3.16 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] MD 1945 to June 1 1945 and that I last saw h.im alive on June 1 1945

Immediate cause of death	DURATION
Coronary Occlusion.	2 mos.
Due to Arteriosclerosis.	6 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address [illegible] Date signed 6/2/45

RECEIVED
JUN 6 1945
BUREAU V. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06394

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59 years

Hospital, institution, or street address where death occurred:

138 N. Potomac Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 138 N. Potomac St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William David Hammond M. D.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Camilla Hammond

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8, 1885

8. AGE:

Years	Months	Days	If less than one day
59	11	17	hrs. min.

9. Birthplace: Hagerstown Wash Co., Md. (Town, county, and state)

10. Usual occupation: Medical Doctor

11. Industry or business

FATHER

12. Name: William I. Hammond

13. Birthplace: Hagerstown, Md.

MOTHER

14. Maiden name: Lillie McComas

15. Birthplace: Washington County, Md.

16. Informant: Miss Stella Heil

Address: 138 N. Potomac Street- Hagerstown, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof June 25 1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill Crematory

Location: Washington, D. C.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. June 25 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 1945 about 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Gun shot through skull	
32 bullet	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: June 25/45

Accident, suicide, or homicide: Suicide Date of

Where did injury occur? Hagerstown, Wash. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Shot self with revolver Injured at work?

23. SIGNATURE: S Rubert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.

Address: Hagerstownm, Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 28 1945
BUREAU V. S.

06395

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (86-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 91 years

Hospital, institution, or street address where death occurred: 138 N. Potomac Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. 138 N. Potomac Street (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William L. Hammond

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Lillie McComas

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 30, 1854

8. AGE: Years	Months	Days	If less than one day
91	0	26	hrs. min.

9. Birthplace: Hagerstown, Wash. Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Bank Employee

FATHER 12. Name: David C. Hammond

FATHER 13. Birthplace: Washington County, Md.

MOTHER 14. Maiden name: Catherine Hoffman

MOTHER 15. Birthplace: Washington County, Md.

16. Informant: Dr. William D. Hammond

Address: Hagerstown, Md. 138 N. Potomac St.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof June 26, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill Crematory

Location: Washington, D. C.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. June 25 1945 (Date rec'd by registrar) Chas. H. Board Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1945 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Chr. myocarditis	5yrs
Due to: Fractured femur (closed)	2m0
Due to: Accidental fall. Dwg.	
Slipped and fell on floor of home, March	
Other conditions: 20th, 1945.	

(Include pregnancy within 3 months of death)

Major findings of operation: no

Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: S. Roland Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.

M. D.

Address: Hagerstown, Md. Date signed: June/24/45

VS A15

PLEASE WRITE PLAINLY, WITH INDELIBLE FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 28 1945
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

06395

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH:

County: Washington

City or town: Rural Plesant Ville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Rural - Plesant Ville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Annie C. Hanes

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Barton H. Hanes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 9 1869

8. AGE: Years	Months	Days	If less than one day
76	4	3	..... hrs. ..... min.

9. Birthplace: Orleans Road Alleganey, Co
(Town, county, and state)

10. Usual occupation: House Keeping

11. Industry or business: Home

FATHER 12. Name: Jesse W. Weaver

FATHER 13. Birthplace: Orleans Road Alleganey, Co.

MOTHER 14. Maiden name: Sarah E. Barnes

MOTHER 15. Birthplace: Orleans Road Alleganey, Co.

16. Informant: G.W. Hanes

Address: Engle, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14 1945 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Samples Manor, Md.

19. Funeral director: J. H. Backles.

Address: Bolivar, W.Va.

19. June 12 (Date rec'd by registrar) 19 45 Cornelius W. Castle Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12 19 45 9:00 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 16, 1945, to May 16, 1945 and that I last saw her alive on May 16 1945

	DURATION
Immediate cause of death: Broken left hip	May 16, 1945
Due to: Has had 3 attacks of Cerebral hemorrhage	
Due to:	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of May 16, 1945

Where did injury occur? In Home - Harpers Ferry R.F.D. 1
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Fall Injured at work? No

23. SIGNATURE: S.G. Moore M. D. or other

Address: Harpers Ferry WVa Date signed 6/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 15 1945
BUREAU V.P.

Dr. Prather

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63)

CERTIFICATE OF DEATH

06397

Reg. Dist. No. 362

1. PLACE OF DEATH:

County: Washington

City or town: Hagesrtwon

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 Yesrs

Hospital, Institution, or street address where death occurred:

233 South Mulberry St.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagesrtwon

(If outside city or town limits, write RURAL and give nearest town)

Street No. 233 South Mulberry St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Raymond Talbert Harbaugh

3. (b) Social Security Number: 214-09-3993

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nettie P.

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): October 8 1889

8. AGE: Years	Months	Days	If less than one day
55	8	3	....hrs. ....min.

9. Birthplace: Lantz Fred. Co. Md.
(Town, county, and state)

10. Usual occupation: Plumber

11. Industry or business: Grove Plumbing Co

FATHER — 12. Name: Oliver Harbaugh

FATHER — 13. Birthplace: Lantz Md.

MOTHER — 14. Maiden name: Anna Brown

MOTHER — 15. Birthplace: Lantz Md.

16. Informant: Mrs. Nettie Harbaugh

Address: Hagerstown M.d

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/13/45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagesrtwon Md.

19. June 12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: June 11 1945 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to June 11 1945 and that I last saw him alive on June 11 1945

Immediate cause of death	DURATION
Bronchio pneumonia	2 dc.
Due to	
Due to	
Other conditions: Hypertensive Renal disease (Include pregnancy within 3 months of death)	6 mo

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ....Injured at work?

23. SIGNATURE: W. F. Prather M. D.

Address: Hagerstown Date signed 6/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 14 1945
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

Dr. Victor Miller

66400

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Leitersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. Hagerstown - Waynesboro Pike

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: William Adam Hebb

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Myrtle

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): June 26 1870

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
75	-	-		

9. Birthplace: Sharpsburg Wash. Co. Md (Town, county, and state)

10. Usual occupation: Instructor

11. Industry or business: Gavernment Repair Shop

FATHER — 12. Name: John Hebb

FATHER — 13. Birthplace: Sharpsburg Md.

MOTHER — 14. Maiden name: Mary C. Seiss

MOTHER — 15. Birthplace: Sharpsburg Md.

16. Informant: Clyde E. Hebb

Address: Waynesboro Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/29/45 (month) (day) (year)

Cemetery or crematory: Reformed Cemetery

Location: Leitersburg Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. June 27 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1945 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/14 1945 to 6/26 1945 and that I last saw h. alive on 6/26 1945

Immediate cause of death: Chronic Suba cute

" arterio-sclerosis ?

Due to: Heat Prostration.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dr. Victor D. Miller M. D. or other

Address: 131 W. Washington, St. Date signed: 6-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 29 1945
BUREAU V. F.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (60)

06398

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 10 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 43 Roessner Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Edna Etter Hege

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Hugh B. Hege
6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Dec. 25 1901

8. AGE: Years	Months	Days	If less than one day
43	5	18	hrs. min.

9. Birthplace Near Chambersburg Franklin Pa.
(Town, county, and state)
10. Usual occupation House Wife
11. Industry or business Own Home

FATHER
12. Name J. Frank Etter
13. Birthplace Near Chambersburg Pa.

MOTHER
14. Maiden name Jane Snively
15. Birthplace Near Chambersburg Pa.

16. Informant Mr. Hugh B. Hege
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16, 1945 (month) (day) (year)
Cemetery or crematory Salem Luthern Church
Location Marion Pa.

18. Funeral director Scott F. Minnich & Son
Address Hagerstown Md.

19. June 16 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 10:55a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1945 to June 13 1945
and that I last saw h[illegible] alive on June 13 1945

Immediate cause of death	DURATION
Carcinoma of liver	6 mos
Due to Carcinoma of breast	3 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE B F Rathvon M. D. or other
Address Hagerstown Date signed 6/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 19 1945
BUREAU V.R.

Dr Ditto

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-1)

CERTIFICATE OF DEATH

06399

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Years

Hospital, institution, or street address where death occurred:
922 Pennsylvania Ave

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 922 Penna. Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: World War # 1

3. (a) FULL NAME: Boyd Biever Heiges

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella M.

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): July 16 1896

8. AGE: Years	Months	Days	If less than one day
48	11	11	....hrs. ....min.

9. Birthplace: Scotland Franklin Co. Pa.
(Town, county, and state)

10. Usual occupation: Restaurant Operator

11. Industry or business: Heiges Restaurant

FATHER
12. Name: Schuyler C. Heiges
13. Birthplace: Dillsburg Pa.

MOTHER
14. Maiden name: Mary E. Biever
15. Birthplace: Dillsburg Pa.

16. Informant: Mrs. Ella M. Heiges
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/29/45 (month) (day) (year)

Cemetery or crematory: River View Cemetery

Location: Huntingdon Pa.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. June 27 1945 (Date rec'd by registrar) Blair Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 1945 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 - 1945 to June 27 1945 and that I last saw him alive on June 26 - 45 1945

Immediate cause of death	DURATION
Cancerum	
Due to Throat	6 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D. W. Lutz M. D. or other

Address: Hagerstown Md. Date signed: 6-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 29 1945
BUREAU V. S.

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(T)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

06401

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
57 East Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 57 East Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Frank M. Hoffhine

3. (b) Social Security Number 214-09-8276

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1873

8. AGE: Years	Months	Days	If less than one day
72	1	27	hrs. min.

9. Birthplace Quincy, Pa.
(Town, county, and state)
10. Usual occupation Retired Clerk
11. Industry or business

FATHER
12. Name Jacob Hoffhine
13. Birthplace Waynesboro, Pa.

MOTHER
14. Maiden name Ann Elizabeth Winter
15. Birthplace Cavetown, Maryland

16. Informant Miss Flossie Hoffhine
Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-5-45 (month) (day) (year)
Cemetery or crematory Cavetown Cemetery
Location Cavetown, Maryland

18. Funeral director C. M. Suter & Sons
Address Hagerstown, Maryland

19. June 4 1945 (Date rec'd by registrar) Chas. H. Boward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945 at 11:15 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1943 to June 2 1945 and that I last saw h... alive on June 1, 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Chronic Myocarditis	
Due to Diabetes Mellitus	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. P. Stauffer M. D. or other
Address Hagerstown Md Date signed June 4, 45

RECEIVED
JUN 6 1945
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

CERTIFICATE OF DEATH

16402

Reg. Diat. No. 305

1. PLACE OF DEATH:

County: Washington

City or town: Clevelandville Rural.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life.

Hospital, Institution, or street address where death occurred:
Boonsboro Md. R. 2.

How long in hospital or institution? at Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Clevelandville Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Boonsboro Md. R. 2
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Albert Samuel Hutzell

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Martha P. Hutzell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January - 15 - 1900

8. AGE: Years	Months	Days	If less than one day
45	5	5	..... hrs. ..... min.

9. Birthplace: Gittlestown Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: General Store

FATHER
12. Name: Joseph Hutzell
13. Birthplace: Near Boonsboro Wash. Co. Md.

MOTHER
14. Maiden name: Effie May Moser
15. Birthplace: Near Myersville Fred. Co. Md.

16. Informant: Mrs. Martha P. Hutzell
Address: Boonsboro Md R. 2

17. Burial (Burial, cremation, or removal, Which?) Date thereof June - 23 1945 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetery

Location: Boonsboro Md.

18. Funeral director: Wm J. Bast & Sons

Address: Boonsboro Md.

19. June - 21. 1945 (Date rec'd by registrar) John H. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 19 45, at 6.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 19 45, to June 20 19 45 and that I last saw him alive on June 20 19 45

Immediate cause of death	DURATION
Acute myocarditis with decompensation.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G. W. Libby, M. D.
M. D. or other

Address: Boonsboro Date signed 6/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 22 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

06473

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington (OUTSIDE CITY LIMITS)
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland (OUTSIDE CITY LIMITS) County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 333 Elizabeth Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thelma Jane Jordon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

B.(b) Name of husband or wife

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 7, 1938

8. AGE: Years	Months	Days	If less than one day
6	11	24	..... hrs. ..... min.

B. Birthplace Hagerstown, Wash., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Ernest P. Jordon
13. Birthplace Funkstown, Md.

MOTHER 14. Maiden name Nina Irene Goetz
15. Birthplace Hagerstown, Md.

16. Informant Ernest P. Jordon
Address Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 3, 1945 (month) (day) (year)
Cemetery or crematory Rest Haven Cemetery
Location Hagerstown, Md.

18. Funeral director Scott F. Minnich & Son
Address Hagerstown, Md.

19. June 3, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1945, at 12:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Extensive 3rd degree burns	
to body, forearms, and	6½ hrs
Due to thighs	
Due to toxemia and shock	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of May/31/45
Where did injury occur? Hagerstown (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Alley in rear of Elizabeth St.
Means of injury Clothing caught fire Injured at work? No

23. SIGNATURE J. Robert Wellso DEPUTY MEDICAL EXAM. WASH. CO., MD.
Address Hagerstown, Md. M. D. or Coroner Date signed June 1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 5 1945
BUREAU U.S.

06414

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH (1610)

County Washington. Registration Dist. No. 302

Village or City Hagerstown. No. Washington County Hosp. St., 3 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. 4 ds. How long in U.S. If of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME ROWAN ELIZABETH KEEFER If U. S. Veteran, specify WAR ____

(a) Residence: No. ____ Mercersburg, Rt. #2 St., ____ Ward. Penna. ____

(Usual place of abode) If nonresident give city or town and State ✓

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	W.	Single

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ____

6. DATE OF BIRTH (month, day, end yeer) JUNE 27. 1945

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
			4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None.

9. Industry or businass in which work was done, as SILK MILL, SAW MILL, BANK, etc. None.

10. Date deceased last workad at this occupation (month end yeer) ____

11. Total time (years) spant in this occupation ____

12. BIRTHPLACE (city or town) Hagerstown. (Stata or country) Maryland.

FATHER

13. NAME Ray Wilson Keefer

14. BIRTHPLACE (city or town) Mercersburg (Stete or country) Penn'a.

MOTHER

15. MAIDEN NAME Dorothy Truane Whaler

16. BIRTHPLACE (city or town) HUNTSDALE (State or country) Penn'a.

17. INFORMANT Ray W. Keefer. (Address) Mercersburg, Pa.

18. BURIAL, CREMATION, OR REMOVAL Place Mercersburg Pa RR 2 Date July 2, 1945

19. UNDERTAKER D. J. Luitger & Son (Address) Mercersburg Pa.

20. FILED July 1, 1945 Grace H. Bowers, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH JUNE (Month) 30 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended decaasad from JUNE 27, 1945, to JUNE 30, 1945

I lest saw hAR alive on JUNE 30, 1945; death is said to have occurred on the date stated abova, at 10:15 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance ware as follows:

	Date of onset
ERYTHROBLASTOSIS FOETALIS	JUNE 27-1945
Other Contributory Causes of importence: NEW BORN	

Name of operetion None. Dete of ____

What test confirmed diagnosis? Laboratory Was there an autopsy? YES.

23. If daath was due to extarnal causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19____

Whara did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disaase or injury in any way related to occupation of deceased? Yes

If so, specify New Born.

(Signad) Archie Robert Cline M. D.

(Address) Clearspring Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

U.S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

JUL 3 1945

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-F)

06405

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:
County Washington
City or town Boonsboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years.
Hospital, Institution, or street address where death occurred:
S. Main St.
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Boonsboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. S. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Otto Winters King

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Emma King
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July - 26 - 1873

8. AGE:

Years	Months	Days	If less than one day
71	10	17	..... hrs. ..... min.

9. Birthplace Briggsdale Wash. Co. Md.
(Town, county, and state)
10. Usual occupation Merchant
11. Industry or business General Store
FATHER 12. Name Samuel King
13. Birthplace Pennsylvania
MOTHER 14. Maiden name Mary Diamond
15. Birthplace near Smithsburg Wash. Co. Md.
16. Informant S. Pierce King
Address Boonsboro Md.
17. Burial. (Burial, cremation, or removal. Which?) Date thereof June - 16. 1945 (month) (day) (year)
Cemetery or crematory Boonsboro Cemetary
Location Boonsboro Md.
18. Funeral director Wm J. Bast & Sons
Address Boonsboro Md.
19. June - 14. 1945 (Date rec'd by registrar) John W. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 6:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2 1945, to June 13 1945
and that I last saw him alive on June 13 1945

Immediate cause of death	DURATION
Chronic Myocarditis	5 yrs.
Due to Chronic nephritis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE G. W. Gilbert M.D.
M. D. or other
Address Boonsboro Date signed 6/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 16 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (No. 1)

CERTIFICATE OF DEATH

Reg. Dist. No. 06411 -302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hours

Hospital, Institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Clear Spring, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

Present member of U. S. Navy

2.(a) If veteran, name war

3. (a) FULL NAME: Richard Edward Kinsell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 23, 1908

8. AGE:

Years	Months	Days	If less than one day
36	10	29	..... hrs. ..... min.

9. Birthplace: Washington County, Md.
(Town, county, and state)

10. Usual occupation: Machinest

11. Industry or business

FATHER

12. Name: Bernard M. Kinsell

13. Birthplace: Wash. Co., Md.

MOTHER

14. Maiden name: Elsie Elsiel

15. Birthplace: Franklin Co., Pa.

16. Informant: Bernard M. Kinsell

Address: Clear Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21, 1945 (month) (day) (year)

Cemetery or crematory: St. Paul's Cemetery

Location: Near Clear Spring, Md. Route 40

18. Funeral director: Snyder-Rowland Funeral Home

Address: Clear Spring, Md.

19. June 22 1945 (Date rec'd by registrar) C Kail Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18, 1945 5:45 P.M. (M)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Fractured skull	
Due to: Hemorrhage & shock	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 6/18/45

Where did injury occur? West of Clear Spring, Washington, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway, 1 mile West Clear Spring

Means of injury: Motorcycle crash Injured at work? No

23. SIGNATURE: H. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.

Address: Hagerstown, Md. Date signed 6/20/45

RECEIVED
JUN 25 1945
BUREAU V.S.

Dr. Kohler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Chewsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 Years
Hospital, institution, or street address where death occurred:
Chewsville Pike
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Chewsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Chewsville Pike
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME George Eldon Krouse

3.(b) Social Security Number 216-03-8465

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Clara M.
6.(c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) August 10 1877

8. AGE: Years	Months	Days	If less than one day
67	9	23	..... hrs. ..... min.

9. Birthplace Chewsville Wash. Co. Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Chewsville Milling Co.
FATHER 12. Name Daniel Krouse
13. Birthplace Smithsburg Md.
MOTHER 14. Maiden name Anna Stonebraker
15. Birthplace Hagerstown Md.
16. Informant Mrs. Anna Krouse
Address Chewsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/5/45 (month) (day) (year)
Cemetery or crematory Lutheran Cemetery
Location Beaver Creek Md.
18. Funeral director Andrew K. Coffman
Address Hagesrtwon Md.
19. June 4 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1945 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14 1944 to June 3 1945 and that I last saw h... alive on June 3 1945

	DURATION
Immediate cause of death Mesenteric Thrombosis	3 hours
Due to Thrombo Angitis Obliterans of left leg	2 mos
Due to Arteriosclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. E. Kohler M. D. or other
Address Smithsburg Date signed 6/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 6 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

06408

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown Rural -Fiddlersburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
On Highway near Fiddlersburg
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Harry Franklin McCoy

3. (b) Social Security Number: 217-12-1992

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella V. McCoy
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 19, 1886

8. AGE: Years	Months	Days	If less than one day
59	3	8	..... hrs. ..... min.

9. Birthplace: Washington County, Md.
(Town, county, and state)
10. Usual occupation: Employee of Fairchild
11. Industry or business: Aircraft Co.

FATHER
12. Name: Benjamin F. McCoy
13. Birthplace: Washington Co., Md.

MOTHER
14. Maiden name: Amanda Shank
15. Birthplace: Wash. Co., Md.

16. Informant: Mrs. Allen E. Ocker
Address: 603 Md. Avenue- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 30, 1945 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. June 30 1945 (Date rec'd by registrar) C. Kost Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 '45 12 night 1945 (day) (hour) (year)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
coronary occlusion	30 days
Due to: acute ventricular	
fibrillation	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no
Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

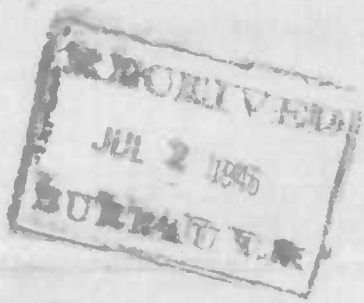
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. Richard Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.
M. D. or other
Address: Hagerstown, Md. Date signed 6/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
JUL 2 1945
BUREAU V.R.

Evidence for change of age is shown on

FILM 96 JUN 29 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

CERTIFICATE OF DEATH

064[illegible]

Reg. Dist. No. 301

1. PLACE OF DEATH:
County Washington
City or town Williamsport R.F.D.#1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No. #$Vermont St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frances Emma McElroy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Female White	Married

6.(b) Name of husband or wife David McElroy

6.(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) Nov. 12 1921

8. AGE: Years	Months	Days	If less than one day
24 23	7	10	hrs. min.

9. Birthplace Williamsport R.F.D. #1 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Elmer Guessford

13. Birthplace Clearspring R.F.D.

MOTHER 14. Maiden name Jennie Hose

15. Birthplace Clearspring R.F. D.

16. Informant David McElroy

Address Williamsport Md

17. Burial June Date thereof June 21 1945 (month) (day) (year)
(Burial, cremation, or removal. Which?)

Cemetery or crematory GreenLawn Cem

Location Williamsport Md.

18. Funeral director Edith V. Leaf

Address Williamsport Md

19. June 21 19 45 Mrs C. Lee McElroy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 19 45, at about 9:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suffocation by	
Due to drowning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations No

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date June 17/45
Where did injury occur Williamsport R F D Washington Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Potomac River
Means of injury Boat overturned Injured at work? No

23. SIGNATURE Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.
M. D. or Coroner
Address Hagerstown Md. Date signed June 19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 23 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

06410 Reg. Dist. No. 301

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Washington

City or town Rural Downsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred: Potomac River near Downsville, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. East Washington Street Extd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Leslie S. Michael

3.(b) Social Security Number 214-09-4078

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Elsie I. Michael

6.(c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) March 29, 1905

8. AGE: Years	Months	Days	If less than one day
40	2	19	hrs. min.

9. Birthplace Morgantown, W.Va.
(Town, county, and state)

10. Usual occupation Mechanic

11. Industry or business City of Hagerstown

FATHER 12. Name Shannon I. Michael

FATHER 13. Birthplace Morgantown, W.Va.

MOTHER 14. Maiden name Carrie F. Graham

MOTHER 15. Birthplace Morgantown, W.Va.

16. Informant Mrs. Leslie S. Michael

Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-21-45 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C.M. Suter & Sons

Address Hagerstown, Maryland

19. June 20, 1945 (Date rec'd by registrar) Mrs. Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945 at about 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Suffocation by Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

~~Accident~~, suicide, or homicide? Accident Date of 6/17/45

Where did injury occur? Near Downsville (City or town) Washington Co. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Potomac River

Means of injury Drowning Injured at work? No

23. SIGNATURE L. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.

Address Hagerstown, Md. Date signed 6/19/45

RECEIVED
JUN 25 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06411

Reg. Dist. No. 305

1. PLACE OF DEATH:
County: Washington
City or town: Breathedsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7/23/43
Hospital, institution, or street address where death occurred:
Md. State Reformatory for Males
How long in hospital or institution? 7/23/43

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ~~Baltimore~~
City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1420 E. Madison Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: MILLER, Albert

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 4/11/14

8. AGE: Years	Months	Days	If less than one day
31	2	---	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: -----

FATHER
12. Name: William Miller
13. Birthplace: Maryland

MOTHER
14. Maiden name: Florence Miller
15. Birthplace: Maryland

16. Informant: Md. State Reformatory for Males
Address: Breathedsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14 1945 (month) (day) (year)
Cemetery or crematory: Mt Calvery
Location: md
18. Funeral director: Elroy O. Wilson
Address: 1000 Brentley ave

19. June 11 1945 (Date rec'd by registrar) John H. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11, 1945 at 2:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1943 to 6-11 1945 and that I last saw him alive on June 9 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert P. Conrad, M.D. (M. D. or other)
Address: Hagerstown, Md. Date signed: 6-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 13 1945
BUREAU V. R.

Dr. Conrad

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 0641?

Reg. Dist. No. 305

1. PLACE OF DEATH:
County: Washington
City or town: Breathedsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Mos
Hospital, institution, or street address where death occurred:
Md. State Reformatory for Males
How long in hospital or institution? 8 Mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: [redacted]
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 504 West Biddle St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None ✓

3. (a) FULL NAME: Alexander Miller

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): June 23 1914

8. AGE: Years	Months	Days	If less than one day
30	11	22	...hrs. ...min.

9. Birthplace: Hamlet Richmond Co. No. Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: --

FATHER
12. Name: James Miller
13. Birthplace: Hamlet No. Carolina

MOTHER
14. Maiden name: Maggie Miller
15. Birthplace: Hamlet Noo Carolina

16. Informant: Md. State Ref. for Males
Address: Breathedsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/18/45 (month) (day) (year)
Cemetery or crematory: Reformatory Cemetery
Location: near Breathedsville Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. June 18. 1945 (Date rec'd by registrar) John W. Bast Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: June 15 1945 19... at 3.45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov 1 19 45 to June 15 19 45
and that I last saw h... alive on June 14 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Robert P. Conrad M.D. M. D. or other
Address: Hagerstown, Md. Date signed 6-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 22 1945
BUREAU V.M.

Copy (Copied from Form V.S. 1A - Slightly different wording from this form

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-O)

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH:
County: Washington
City or town: Tregg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother) 06413
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hattie Catherine Miller

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George C. Miller
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 7, 1880

8. AGE: Years	Months	Days	If less than one day
64	3	22	hrs. min.

9. Birthplace: Burkittsville, Fred. Co., Md. (Town, county, and state)
10. Usual occupation: Home duties
11. Industry or business: " "

FATHER
12. Name: Albert A. Hemp.
13. Birthplace: Jefferson, Md.

MOTHER
14. Maiden name: Jane Olivia
15. Birthplace: Jefferson, Md.

16. Informant: Clarence H. Miller
Address: Rohrersville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: July 2 1944 (month) (day) (year)
Cemetery or crematory: Lutheran Cemetery
Location: Locust Grove

18. Funeral director: R. I. Earnshaw
Address: Keedysville, Md.

19. June 30 1944 Mrs. Katherine Dagenhart
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29 1944 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10. 1944 to June 29 1944
and that I last saw her alive on June 29 1944

Immediate cause of death	DURATION
Uraemia	6 mo.
Myocarditis	10 yrs.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: G. W. LeVan, M. D.
M. D. or other
Address: Boonsboro, Md. Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 1945
BUREAU V S.

Evidence for change of year of death is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33)

CERTIFICATE OF DEATH

06414

FILM No. G 96 JUN 29 1945

Reg. Dist. No. 305

1. PLACE OF DEATH:
County Washington
City or town Tilghmanton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Tilghmanton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Franklin Mongan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1866

8. AGE: Years	Months	Days	If less than one day
78	9	19	hrs. min.

9. Birthplace Tilghmanton-Wash.- Maryland (Town, county, and state)
10. Usual occupation Stone-Mason
11. Industry or business

FATHER
12. Name Frisby Mongan
13. Birthplace Tilghmanton, Md.

MOTHER
14. Maiden name Margret Moats
15. Birthplace Tilghmanton

16. Informant Mrs. Jeremiah Mongan
Address Tilghmanton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 24 1944 (month) (day) (year) 1945
Cemetery or crematory Manor
Location Near Tilghmanton
18. Funeral director R. I. Earnshaw
Address Keedysville, Md.

19. June 25 1945 (Date rec'd by registrar) John H. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945, 2P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1945, to June 21 1945
and that I last saw h.. alive on June 21 1945

Immediate cause of death	DURATION
Myocarditis Senilis	3 Years
Due to Arterio Sclerosis	10 Yrs
Other conditions Prostate, Inguinal Hernia	5 Years

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. D. or other
Address Williamsport Md. Date signed 6/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 27 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Dr. Kneisley

06415

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? I2 Yrs.

Hospital, institution, or street address where death occurred:

222 Winter St. Hagerstown, Md.

How long in hospital or institution? I2 Yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wash.

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 222 Winter St

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Indiana Conrad Moore

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: William

6.(c) If alive, give age: —— years

7. Birth date of deceased (mo., day, yr.): Nov. 7 I87I

8. AGE: Years	Months	Days	If less than one day
73	7	6	....hrs. ....min.

9. Birthplace: Hopewell Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: ——

FATHER — 12. Name: Benj. Conrad

FATHER — 13. Birthplace: Welsh Run Pa.

MOTHER — 14. Maiden name: Martha Rummell

MOTHER — 15. Birthplace: Waynesboro Pa.

16. Informant: Ralph C Moore

Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/I5/45 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Hagerstown, Md.

18. Funeral director: Andrew K Coffman

Address: Hagerstown Md.

19. June 14 19 45 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13 1945 19..., at 6.45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1945 19... to June 13 19 45 and that I last saw her alive on June 19 45

Immediate cause of death	DURATION
Coronary occlusion	1 day
Due to: Coronary sclerosis	(Indef.)
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: B. B. Kneisley M.D. M. D. or other

Address: 148 W. Washington St., Date signed 6/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

R.E.
JUN 16 1941
BUREAU V.I.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06416

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:
Hagerstown Route 3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown Route 1
(If outside city or town limits, write RURAL and give nearest town)

Street No. Trovinger Mill near Chewsville, Md
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Edna E. Moser

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 17, 1901

8. AGE: Years	Months	Days	If less than one day
43	9	24	..... hrs. ..... min.

9. Birthplace Keedysville, Wash.Co.Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Henry C. Marshall
13. Birthplace Sharpsburg, Maryland

MOTHER
14. Maiden name Annie M. Hines
15. Birthplace Locust Grove, Maryland

16. Informant Mrs. Wilson Burner

Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-13-45 (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. June 11 19 45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1945 at 8:30A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11, 1945 19..... to June 10 19 45

and that I last saw her alive on June 7, 19 45

Immediate cause of death	DURATION
Intestinal Obstruction	6 days
Due to Carcinoma of rectum	Indef.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Carcinoma of rectum (Mosserle) Date of op. 3/27/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [signature] M.D. or other

Address 148 W. Washington St. Date signed 6/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 13 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06417 300
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH
County Washington
City or town Rural
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Sharpsburg Md
Stay in hospital or inst (yrs., or mos., or days) not any
Stay in this community (yrs., or mos., or days) 3 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Sharpsburg Md
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME CLARENCE LOVELL NETT

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Mollie Smith
6(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1879

8. AGE: Years 65 | Months 7 | Days 15 | If less than one day ____ hrs. ____ min.

9. Birthplace Louisville Ky
(Town, county, and state)

10. Usual occupation Supt. National Park

11. Industry or business Proprietary U.S. Govmt

FATHER 12. Name James P. Nett
13. Birthplace Ky.

MOTHER 14. Maiden name Annie E. Pauson
15. Birthplace Ky

16. Informant Mrs. Mollie Nett
Address Sharpsburg Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 6/5/45 (month) (day) (year)
Cemetery or crematory National Cemetery
Location Gettysburg, Pa.

18. Funeral director Walter Beadle
Address Gettysburg Pa.

19. 6-1 (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1945, at 6.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1945, to June 1 1945;
and that I last saw him alive on June 1 1945.

Immediate cause of death	DURATION
Coronary Thrombosis	1 hour
Due to Angina Decubitus	5 days
Due to Generalized Arteriosclerosis	9 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE Walter L. Shrady M.D.
M. D. or other
Address Sharpsburg, Md. Date signed 6/1/45

RECEIVED
JUN 6 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

CERTIFICATE OF DEATH

76418

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 141 N. Potomac Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Otho J. Poffenberger

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE: Years	Months	Days	If less than one day
78			hrs. min.

9. Birthplace: Washington County, Md. (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER 12. Name: Elias Poffenberger

13. Birthplace: Wash. Co., Md.

MOTHER 14. Maiden name: Mary Showman

15. Birthplace: Wash. Co., Md.

16. Informant: Harry C. Poffenberger

Address: 734 Guilford Ave.-Hagerstown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 4, 1945 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetery

Location: Boonsboro, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. June 4 1945 (Date rec'd by registrar) Chas. H. Boward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2, 1945 9:30 A.M. or P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 1944 to June 2, 1945

and that I last saw him alive on June 1, 1945

Immediate cause of death	DURATION
Chronic Myocarditis	1 year
Due to:	
Due to:	
Other conditions: Arteriosclerosis	

(Incinde pregnancy within 3 months of death)

Major findings of operations: There was no operation. Date of op.:

Autopsy results: There was no autopsy.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. A. Bell M. D. or other

Address: Hagerstown, Maryland Date signed: 6-2-45

RECEIVED
JUN 6 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-b)

CERTIFICATE OF DEATH

06419

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 81 years
Hospital, institution, or street address where death occurred:
311 Frederick St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 311 Frederick St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME John E. Powell

3.(b) Social Security Number 220-18-2076

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Nettie M. Powell
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1863

8. AGE: Years	Months	Days	If less than one day
81	6	23	..... hrs. ..... min.

9. Birthplace Middleburg Franklin Pa.
(Town, county, and state)
10. Usual occupation None
11. Industry or business None
FATHER 12. Name John Powell
13. Birthplace Middleburg Pa.
MOTHER 14. Maiden name Ellen L. Orris
15. Birthplace Middleburg Pa.
16. Informant Mr. Lawrence Powell
Address Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23, 1945 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md.
18. Funeral director Scott F. Minnich & Son
Address Hagerstown Md.
19. June 21 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1945 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940, to June 20 1945 and that I last saw h. alive on 6/16 1945

Immediate cause of death	DURATION
Chronic Endocarditis	2
Chronic Nephritis	4
Due to Hypertrophy Prostate	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Victor D. Miller M. D. or other
DR. VICTOR D. MILLER
Address 131 W. WASHINGTON, ST HAGERSTOWN, MD. Date signed 6/20/1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 23 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-7)

CERTIFICATE OF DEATH

06420

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mths
Hospital, Institution, or street address where death occurred:
Washington Co Hospital
How long in hospital ~~or institution~~? 2 mths.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. ~~Hallo Co Hospital~~
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME Dr. Jacob Protzman

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife none

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-10-1856

8. AGE: Years	Months	Days	If less than one day
89	11-	25	— hrs. — min.

8. Birthplace New Town Va
(Town, county, and state)
10. Usual occupation Dr.
11. Industry or business Dr.
FATHER 12. Name David Protzman
13. Birthplace New Hagerstown
MOTHER 14. Maiden name Sarah Bruger
15. Birthplace Pa
18. Informant Mrs Alice Garnand
Address Smithsburg R.F.D.
17. (Burial, cremation, or removal, which?) Burial. Date thereof 6-7-1945 (month) (day) (year)
Cemetery or crematory Walters
Location Mar. Smithsburg md
18. Funeral director Geo. B. Power
Address Smithsburg md
18. (Date rec'd by registrar) June 6 1945 Registrar Chas H Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945, at 2.30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945 to June 5 1945 and that I last saw him alive on June 5 1945

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs
Due to Chronic nephritis	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE G W Lehn M.D.
M. D. or other
Address Boonsboro Date signed 6/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 8 1945
BUREAU V.E

STATE OF MARYLAND—CERTIFICATE OF DEATH (16421)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (131-6)

County Washington Registration Dist. No. 307

Village or City Sandy Hook, Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 73 yrs. 35 mos. 254 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Annabelle Reeser If U. S. Veteran, specify WAR

(a) Residence: No. Sandy Hook, Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel W. Reeser

6. DATE OF BIRTH (month, day, and year): Feb 7 1872

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	35	254	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: House Wife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Home

10. Date deceased last worked at this occupation (month and year): 1944

11. Total time (years) spent in this occupation: 55

12. BIRTHPLACE (city or town) (State or country): Weverton, Md.

FATHER

13. NAME: Silas Himes

14. BIRTHPLACE (city or town) (State or country): Brownsville, Md.

MOTHER

15. MAIDEN NAME: Eliza Ann Deener

16. BIRTHPLACE (city or town) (State or country): Brownsville, Md.

17. INFORMANT: Mr Joseph Himes

(Address): Knoxville, Md R.R. # 1

18. BURIAL, CREMATION, OR REMOVAL

Place: Brownsville, Md. June 5, 19 45

19. UNDERTAKER: J. R. Castles

(Address): Bolivar, W.Va.

20. FILED June 4, 1945 Cornelius H. Castle Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

June (Month) 2 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 15, 1945, to June 2, 1945

I last saw h[illegible] alive on June 1, 1945; death is said to have occurred on the date stated above, at 11:15 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Uremia	May 15 45
Cerebral Hemiplegia	5

Other Contributory Causes of Importance:

Name of operation: Date of:

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) William Schmeltzer M. D.

(Address) Brunswick, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

RECEIVED JUN 7 1945 BUREAU V.S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

CERTIFICATE OF DEATH

★06422

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 hours
Hospital, Institution, or street address where death occurred: Washington County Hospital
How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Washington
City or town: Old Forge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: RFD #5
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Forrest G. Sharpe

3.(b) Social Security Number: 214-09-5968

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Clara B. Sharpe
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): October 12, 1903

8. AGE: Years	Months	Days	If less than one day
41	8	10	...hrs. ...min.

9. Birthplace: Hancock, Wash., Md. (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: Pangborn Corp.

FATHER
12. Name: Remmie Sharpe
13. Birthplace: Hancock, Md.

MOTHER
14. Maiden name: Anna Myers
15. Birthplace: Hancock, Md.

16. Informant: Mrs. Clara B. Sharpe
Address: Old Forge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 25, 1945 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown, Md.

18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown, Md.

19. June 25 1945 (Date rec'd by registrar) Chas H Bovard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22, 1945 at 3:08p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 1945 to June 22 1945 and that I last saw h. alive on June 22 1945

Immediate cause of death: Asthma — Duration: 1 yr
Due to: Coronary Occlusion — Duration: 2 hrs.
Due to: Acute Myocardial Decompensation — Duration: 2 hrs.
Other conditions — Duration:

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Ernest F Poole M.D. M. D. or other
Address: Hagerstown Md Date signed: 6/23/45

RECEIVED
JUN 28 1945
BUREAU OF

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1512)

CERTIFICATE OF DEATH

06423

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, institution, or street address where death occurred: 27 East Antietam Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. 27 East Antietam Street (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Jennie Elima Snyder

3.(b) Social Security Number none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife W. H. Snyder

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) September 15, 1865

8. AGE: Years 79 Months 9 Days 1 If less than one day ... hrs. ... min.

9. Birthplace Tamaqua, Schuylkill Co. Pa. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Gideon Whetstone

13. Birthplace Tamaqua, Pa.

MOTHER 14. Maiden name Katherine Boughner

15. Birthplace Catawissa Valley, Pa.

16. Informant Paul Snyder

Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-19-45 (month) (day) (year)

Cemetery or crematory Odd Fellows Cemetery

Location Tamaqua, Pa.

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. June 18 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16, 1945, at 3.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4, 1927, to June 16 1945 and that I last saw her alive on June 16, 1945

	DURATION
Immediate cause of death: Myocardial Insufficiency &	
Due to Chronic Int. Nephritis	1 yr.
Due to Arteriosclerosis	10 yrs.
Other conditions Chronic Dermatitis	life
Fractured Rt hip.	Apr. 1944

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. —

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? X (City or town) X (County) X (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE W. Howard George M. D. or other

Address Hagerstown, Md Date signed 6-16-45

RECEIVED
JUN 20 1945
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH 06424

1. PLACE OF DEATH

County Washington Registration Dist. No. 302

Village or City Hagerstown No. 410 S. Potomac St., 3 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mary Elizabeth Stauffer If U. S. Veteran, specify WAR

(a) Residence: No. 410 S. Potomac St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	white	widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of David S. Stauffer

6. DATE OF BIRTH (month, day, and year) April 20-1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	2	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Own Home

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Junk ton (State or country) Pa

FATHER

13. NAME Robert Lyle

14. BIRTHPLACE (city or town) Pa (State or country)

MOTHER

15. MAIDEN NAME Harriet May

16. BIRTHPLACE (city or town) Pa (State or country)

17. INFORMANT Mrs. W. F. Norman (Address) 410 S. Potomac St.

18. BURIAL, CREMATION, OR REMOVAL Place Shafer Hill Cemetery Date June 24, 1945

Quincy Pa

19. UNDERTAKER Hoffo & Stone By M. A. Hoffo (Address) 408 Church St New Cumberland Pa.

20. FILED June 21, 1945 Grace H. Boarer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH June 21 (Month) (Day) 45 (Year) 10:55 A

22. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw h... alive on ..., 19...; death is said to have occurred on the date stated above, at ... m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
chr. myocarditis	
acute ventricular fibrillation	
Other Contributory Causes of Importance:	

Name of operation No Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? no Date of injury ..., 19...

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) S. Robert Wells M.D. DEPUTY MEDICAL EXAM WASH. CO., MD. M. D.

(Address) Hagerstown, Md. June 21 1945

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

M

I

T

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED
JUN 23 1945
BUREAU V.S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

T 16425

Reg. Dist. No. 305

1. PLACE OF DEATH:
County: Washington
City or town: Beaver Creek - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
Hagerstown Md. R. 1
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Beaver Creek - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hagerstown Md. R. 1
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Otho Lee Summers

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Bessie Doub Summers
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December - 17 - 1864

8. AGE: Years: 80 | Months: 5 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frederick Co. Md.
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER
12. Name: David Summers
13. Birthplace: Fred. Co. Md.

MOTHER
14. Maiden name: Mary Schildtknecht
15. Birthplace: Fred. Co. Md.

16. Informant: Mrs. Vivian S. Miller
Address: Hagerstown Md. R. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June - 4 - 1945 (month) (day) (year)
Cemetery or crematory: Church of the Brethren Cemetery
Location: Beaver Creek Md.

18. Funeral director: Wm. J. Bast & Sons
Address: Boonsboro Md.

19. June 3 1945 (Date rec'd by registrar) John H. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2nd 1945, at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16th 1945, to June 2nd 1945 and that I last saw him alive on May 26th 1945

Immediate cause of death	DURATION
Chronic Myocarditis	3 Mo. 16 Ds.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John H. Wade M.D.
M. D. or other
Address: Boonsboro, Md. Date signed: 6/3/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 5 1945
BUREAU V.F.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46a) +

CERTIFICATE OF DEATH

#6426

Reg. Dist. No. 302

1. PLACE OF DEATH:

County [redacted] Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

526 Summit Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 526 Summit Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James R. Unseld

3. (b) Social Security Number 214-09-7843

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 14, 1882

8. AGE: Years	Months	Days	If less than one day
62	6	22	hrs. min.

9. Birthplace Shepherdstown, W. Va.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business North American Cement Co.

FATHER 12. Name James C. Unseld

13. Birthplace Shepherdstown, W. Va.

MOTHER 14. Maiden name Nettie Snyder

15. Birthplace Shepherdstown, W.Va.

16. Informant Mrs. Laura Unseld

Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-9-45 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. June 9 1945 Charles H Bowers, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1944, to June 6 1945

and that I last saw him alive on June 6 1945

Immediate cause of death	DURATION
Carcinoma Esophagus	6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. L. Porterfield M.D.
M. D. or other

Address 136 W Washington Date signed 6/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 12 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-5)

CERTIFICATE OF DEATH

5

06427

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, Institution, or street address where death occurred:
516 W. Howard St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 516 W. Howard St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: John C. Varner

3.(b) Social Security Number: 705-10-4618

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nettie V. Varner

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): July 8, 1878

8. AGE: Years	Months	Days	If less than one day
66	11	22	hrs. min.

9. Birthplace: Near Shippensburg Clumb. Pa.
(Town, county, and state)

10. Usual occupation: Turn Table Operator

11. Industry or business: Railroad

FATHER
12. Name: Henry Varner
13. Birthplace: Near Shippensburg Pa,

MOTHER
14. Maiden name: Jane Russel
15. Birthplace: Near Shippensburg Pa.

16. Informant: Mrs. Nettie V. Varner
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3, 1945 (month) (day) (year)
Cemetery or crematory: Beautiful View
Location: Middleburg Md.

18. Funeral director: Scott F. Minnich & Sons
Address: Hagerstown Md.

19. July 3. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1-45 19 June 30-45 19
and that I last saw alive on June 30-45 19

Immediate cause of death	DURATION
Cardiac-Renal	one
Due to: Uremia	year
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E W Dech M. D. or other
Address: Hagerstown Md. Date signed July 3 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUL 6 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Dr. Bowman

06428

Reg. Dist. No. 302

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 240 Hager St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Darwin Belmont Welch

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 23 1945

8. AGE: Years	Months	Days	If less than one day
		1	hrs. ... min.

9. Birthplace: Hagerstown Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business: —

FATHER

12. Name: Keith B. Welch

13. Birthplace: Keyser W.Va.

MOTHER

14. Maiden name: Florette Shirley

15. Birthplace: Martin W. Va.

16. Informant: Mrs. F.E.Welch

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/25/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md/

19. June 25 1945 (Date rec'd by registrar) Chas H Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1945 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/23 1945 to 6/24 1945 and that I last saw h... alive on 6/24 1945

Immediate cause of death	DURATION
Atelectasis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: J S Bowman M D
M. D. or other

Address: Hagerstown, Md. Date signed 6/24/45

RECEIVED
JUN 28 1945
BUREA